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News Flash - Now available -- CMS' Newly Redesigned DMEPOS Competitive Bidding Web Page. This dedicated web page provides one-stop shopping for Medicare providers, suppliers and referral agents who want the most current and reliable information on this new program. You can see the latest announcements and communications sent to the Medicare provider community here as well. The web address is: *http://www.cms.hhs.gov/DMEPOSCompetitiveBid.* We encourage you to bookmark this NEW page as we will continue to post new information and resources!

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Phase 2 Manual Revisions for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

Note: This article is impacted by the Medicare Improvements for Patients and Providers Act of 2008, which was enacted on July 15, 2008. That legislation delays the implementation of the DMEPOS competitive bidding program until 2009 and makes other changes to the program. This article will be further revised and/or replaced as more details of the modified program are available.

Provider Types Affected

All Medicare DMEPOS suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) as well as any providers who refer or order DMEPOS for Medicare beneficiaries.

What You Need To Know

Change Request (CR) 6119, from which this article is developed, is the second installment of, and adds information to, Chapter 36 DMEPOS Competitive Bidding Program in the *Medicare Claims Processing Manual*. CR 5978 provided the first installment of Chapter 36 and details the initial requirements of this program. The companion MLN Matters article to CR5978 is available at

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5978.pdf on the Centers for Medicare & Medicaid Services (CMS) website

Chapter 36 manualizes policies and instructions for Medicare Contractors on the DMEPOS Competitive Bidding Program. Subsequent installments may follow providing additional sections to the chapter.

This article complements MM5978, SE0805, SE0806, and SE0807, which already cover many of the sections of the new chapter being added to the *Medicare Claims Processing Manual*. These articles in combination with this one cover the key sections of Chapter 36.

Background

The Medicare payment for most DMEPOS is currently based on fee schedules. However, in amending section 1847 of the Social Security Act (the Act), section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates a competitive bidding program to replace the current DMEPOS methodology for determining payment rates for certain DMEPOS items that are subject to competitive bidding under this statute.

In compliance with the statute's mandate that this competitive bidding program be phased in beginning in 2007, CMS issued the regulation for the competitive bidding program (published on April 10, 2007 (72 Federal Register 68 (10 April 2007) pp. 17991-18090)). This regulation is available at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid* on the CMS website.

Key Points of CR6119

Key Points of CR6119 that address a number of areas detailed in Chapter 36 of the *Medicare Claims Processing Manual* are as follows:

Home Health Agencies

Home health agencies must submit a bid and be awarded a contract for the DMEPOS Competitive Bidding Program in order to furnish competitively bid items directly to Medicare beneficiaries who maintain a permanent residence in a CBA. If a home health agency is not awarded a contract to furnish competitively bid items, then they must use a contract supplier for these items.

Prescription for Particular Brand, Item, or Mode of Delivery

Contract suppliers are required to furnish a specific brand name item or mode of delivery to a beneficiary if prescribed by a physician or treating practitioner (that is a physician assistant, clinical nurse specialist, or nurse practitioner) to avoid an adverse medical outcome for the beneficiary. The physician or treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome. This documentation should include the following:

- The product's brand name or mode of delivery;

- The features that this product or mode of delivery has versus other brand name products or modes of delivery; and
- An explanation of how these features are necessary to avoid an adverse medical outcome.

If a physician or treating practitioner prescribes a particular brand or mode of delivery to avoid an adverse medical outcome, the contract supplier must either:

- Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner;
- Consult with the physician or treating practitioner to find another appropriate brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner; or
- Assist the beneficiary in locating a contract supplier that can furnish the particular brand of item or mode of delivery prescribed by the physician or treating practitioner.

Any change in the prescription requires a revised written prescription for Medicare payment. A contract supplier is prohibited from submitting a claim to Medicare if it furnishes an item different from that specified in the written prescription received from the beneficiary's physician or treating practitioner.

Payment for Rental of Inexpensive or Routinely Purchased DME

The monthly rental payment amounts for inexpensive or routinely purchased DME (identified using Healthcare Common Procedure Coding System (HCPCS) modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item.

Payment for Oxygen and Oxygen Equipment

The monthly payment amounts for oxygen and oxygen equipment are equal to the single payment amounts established for the following classes of items:

- Stationary oxygen equipment (including stationary oxygen concentrators) and oxygen contents (stationary and portable);
- Portable equipment only (gaseous or liquid tanks);
- Oxygen generating portable equipment (OGPE) only (used in lieu of traditional portable oxygen equipment/tanks);
- Stationary oxygen contents (for beneficiary-owned stationary liquid or gaseous equipment); and
- Portable oxygen contents (for beneficiary-owned portable liquid or gaseous equipment).

In cases where a supplier is furnishing both stationary oxygen contents and portable oxygen contents, the supplier is paid both the single payment amount for stationary oxygen contents and the single payment amount for portable oxygen contents. The payment amounts for purchase of supplies and accessories used with beneficiary-owned oxygen equipment are equal to the single payment amounts established for the supply or accessory.

Change in Suppliers for Oxygen and Oxygen Equipment

The following rules apply when the beneficiary switches from one supplier of oxygen and oxygen equipment to another supplier after the beginning of each round of competitive bidding:

- Noncontract supplier to contract supplier

  In general, monthly payment amounts may not exceed a period of continuous use of longer than 36 months. However, if the beneficiary switches from a noncontract supplier to a contract supplier before the end of the 36-month period, at least 10 monthly payment amounts would be made to a contract supplier that begins furnishing oxygen and oxygen equipment in these situations provided that medical necessity for oxygen continues.

  For example, if a contract supplier begins furnishing oxygen equipment to a beneficiary in months 2 through 26, payment would be made for the remaining number of months in the 36-month period, because the number of payments to the contract supplier would be at least 10 payments. To provide a more specific example, a contract supplier that begins furnishing oxygen equipment beginning with the 20th month of continuous use would receive 17 payments (17 for the remaining number of months in the 36-month period). However, if a contract supplier begins furnishing oxygen equipment to a beneficiary in month 27 or later, no more than 10 monthly payments would be made assuming the oxygen equipment remains medically necessary.

- Contract supplier to another contract supplier

  This rule does not apply when a beneficiary switches from a contract supplier to another contract supplier to receive his/her oxygen and oxygen equipment. In this scenario, the new contract supplier is paid based on the single payment amount for the remaining number of months in the 36-month period assuming the oxygen equipment remains medically necessary.

Payment for Capped Rental DME Items

The monthly rental payment amounts for capped rental DME (identified using HCPCS modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item for each of the first 3 months and 7.5 percent of the single payment amount established for purchase of the item for months 4 through 13.

Change in Suppliers for Capped Rental DME Items

The following rules apply when the beneficiary switches from one supplier of capped rental DME to another supplier after the beginning of each round of competitive bidding:

- Noncontract supplier to contract supplier

  In general, rental payments may not exceed a period of continuous use of longer than 13 months. However, if the beneficiary switches from a noncontract supplier to a contract

supplier before the end of the 13-month rental period, a new 13-month period begins and payment is made on the basis of the single payment amounts described above under "Payment for Capped Rental DME Items". The contract supplier that the beneficiary switches to is responsible for furnishing the item until medical necessity ends, or the 13-month period of continuous use ends, whichever is earlier. On the first day following the end of the new 13-month rental period, the contract supplier is required to transfer title of the capped rental item to the beneficiary. Once the beneficiary switches from a noncontract supplier to a contract supplier, he/she may not switch back to a noncontract supplier if he/she continues to maintain a permanent residence in a competitive bidding area (CBA). If, however, the beneficiary relocates out of the CBA to a non-CBA, then he/she may switch to a noncontract supplier and a new 13-month rental period does not begin.

- Contract supplier to another contract supplier
  If the beneficiary switches from one contract supplier to another contract supplier before the end of the 13-month rental period, a new 13-month period does not begin. This rule applies in situations where the beneficiary changes suppliers within a CBA and in situations where the beneficiary relocates and switches from a contract supplier in one CBA to a contract supplier in another CBA. The contract supplier that the beneficiary switches to is responsible for furnishing the item until medical necessity ends, or the 13-month period of continuous use ends, whichever is earlier. On the first day following the end of the 13-month rental period, the contract supplier is required to transfer title of the capped rental item to the beneficiary.

Payment for Purchased Equipment

Payment for purchase of new equipment (identified using HCPCS modifier NU), including inexpensive or routinely purchased DME, power wheelchairs, and enteral nutrition equipment, is equal to 100 percent of the single payment amounts established for these items. Payment for purchase of used equipment (identified using HCPCS modifier UE), including inexpensive or routinely purchased DME, power wheelchairs, and enteral nutrition equipment, is equal to 75 percent of the single payment amounts established for new purchase equipment items.

Payment for Repair and Replacement of Beneficiary-Owned Equipment

Beneficiaries who maintain a permanent residence in a CBA may go to any Medicare-enrolled supplier (contract or noncontract supplier) for the maintenance or repair of beneficiary-owned equipment, including parts that need to be replaced in order to make the equipment serviceable. Labor to repair equipment is not subject to competitive bidding and, therefore, will be paid in accordance with Medicare's general payment rules. Payment for replacement parts that are part of the competitive bidding program for the CBA in which the beneficiary resides is based on the single payment amount in that CBA for that replacement part. Payment is not made for parts and labor covered under a manufacturer's or supplier's warranty.

Beneficiaries must obtain replacements of all items that are part of the competitive bidding program for the areas in which the beneficiary resides from a contract supplier unless the item is a replacement part or accessory that is replaced as part of the service of repairing beneficiary-owned base equipment (e.g. wheelchair, walker, hospital bed, continuous positive pressure airway device, oxygen concentrator, etc.). All base equipment that is replaced in its entirety because of a change in the beneficiary's medical condition or because the base equipment the beneficiary was using was either lost, stolen, irreparably damaged, or used beyond the equipment's reasonable useful lifetime (see section 110.2.C of chapter 15 of the *Medicare Benefit Policy Manual* at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS website) must be obtained from a contract supplier in order for Medicare to pay for the replacement. Payment for replacement of items that are part of the competitive bidding program for the CBA in which the beneficiary resides is based on the single payment amount for that item. The contract supplier is not required to replace an entire competitively bid item with the same make and model as the previous item unless a physician or treating practitioner prescribes that make and model.

If beneficiary-owned oxygen equipment or capped rental DME that is a competitively bid item for the CBA in which the beneficiary maintains a permanent residence has to be replaced prior to the end of its reasonable useful lifetime, then the replacement item must be furnished by the supplier (contract or noncontract supplier) that transferred ownership of the item to the beneficiary.

Payment for Enteral Nutrition Equipment

The monthly rental payment amounts for enteral nutrition equipment (identified using HCPCS modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item for each of the first three months and 7.5 percent of the single payment amount established for purchase of the item for months 4 through 15.

Maintenance and Servicing of Enteral Nutrition Equipment

The contract supplier that furnishes the equipment to the beneficiary in the 15th month of the rental period must continue to furnish, maintain, and service the equipment after the 15 month rental period is completed until a determination is made by the beneficiary's physician or treating practitioner that the equipment is no longer medically necessary. The payment for maintenance and servicing enteral nutrition equipment is 5 percent of the single payment amount established for purchase of the item.

Traveling Beneficiaries

Beneficiaries, who travel outside their CBA, for example, to visit family members or reside in a State with warmer climates during winter months, need to consider the following three factors when traveling:

- Where to go to obtain a DMEPOS item;
- Identify whether the item is a competitively bid item or not; and
- Determine the Medicare payment amount for that item.

Depending on where the beneficiary travels (whether to a CBA or a non-CBA), the beneficiary may need to obtain DMEPOS from a contract supplier in order for Medicare to cover the item. For example, a beneficiary who travels to a non-CBA may obtain DMEPOS, if medically necessary, from any Medicare-enrolled supplier. On the other hand, a beneficiary who travels to a CBA should obtain competitively bid items in that CBA from a contract supplier in that CBA in order for Medicare to cover the item. The chart below shows whether a beneficiary should go to a contract supplier or any Medicare-enrolled supplier when the beneficiary travels.

Beneficiary Permanently Resides in	Travels to	Type of Supplier
a CBA	a CBA	The beneficiary should obtain competitively bid items in that CBA from a contract supplier located in that CBA if the beneficiary wants Medicare to cover the item.
	a non-CBA	Medicare will cover DMEPOS, if medically necessary, from any Medicare-enrolled DMEPOS supplier.
Non-CBA	a CBA	The beneficiary should obtain the competitively bid item from a contract supplier in the CBA if the beneficiary wants Medicare to cover the item.
	Non-CBA	Medicare-enrolled DMEPOS supplier

Suppliers that furnish DMEPOS items to Medicare beneficiaries who maintain a permanent residence in a CBA and who travel to a non-CBA need to be aware of the public use files at *http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home* on the Competitive Bidding Implementation Contractor (CBIC) website. These files contain the ZIP codes for the CBAs, the HCPCS codes for competitively bid items, and related single payment amounts for competitively bid items. The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. For example:

1. If a beneficiary maintains a permanent residence in a CBA and travels outside of the CBA, payment for a competitively bid item for the CBA in which the beneficiary maintains a permanent residence is the single payment amount for that item in the beneficiary's CBA.
2. When a beneficiary maintains a permanent residence in an area that is not in a CBA and travels to CBA or non-CBA, the supplier that furnishes the item will be paid the fee schedule amount for the area where the beneficiary maintains a permanent residence.

Traveling Beneficiaries and Transfer of Title of Oxygen Equipment or Capped Rental Items

If a beneficiary who has two residences in different areas and uses a local supplier in each area or if a beneficiary changes suppliers during or after the rental period, this does not result in a new rental episode. The supplier that provides the item in the 36th month of rental for oxygen equipment or the 13th month of rental for capped rental DME is responsible for transferring title to the equipment to the beneficiary. This applies to "snow bird" or extended travel patients and coordinated services for patients who travel after they have purchased the item.

Advance Beneficiary Notice (ABN)

Billing Procedures Related to Advance Beneficiary Notice (ABN) Upgrades under the Competitive Bidding Program

In general, an item included in a competitive bidding program must be furnished by a contract supplier for Medicare to make payment. This requirement applies to situations where the item is furnished directly or indirectly as an upgrade. An upgrade is an item with features that go beyond what is medically necessary. An upgrade may include an excess component. An excess component may be an item feature or service, which is in addition to, or is more extensive than, the item that is reasonable and necessary under Medicare coverage requirements. An item is indirectly furnished if Medicare makes payment for it because it is medically necessary and is furnished as part of an upgraded item. The billing instructions for upgraded equipment found in section 120 of chapter 20 of the Medicare Claims Processing Manual (available at *http://www.cms.hhs.gov/manuals/Downloads/clm104c20.pdf* on the CMS website) continue to apply under the DMEPOS Competitive Bidding Program. Consider the following:

1. *Where a beneficiary, residing in a competitive bidding area, elects to upgrade to an item with features or upgrades that are not medically necessary:*

   - Upgrades from a bid item to a non-bid item
     In this situation, Medicare payment will only be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the single payment amount for the medically necessary bid item.

   - Upgrades from a non-bid item to a bid item
     When upgrading from a non-bid to a bid item, Medicare payment is made to a contract supplier on either an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

   - Upgrades from a bid item in one product category (category "S") to a bid item in another product category (category "U")
     In this case, Medicare payment is only made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of the single payment amount for the medically necessary bid item in product category "S".

2. *Where a beneficiary, who does not reside in a competitive bidding area, but travels to a competitive bidding area, elects to upgrade to an item with features that are not medically necessary:*

   - Upgrades from a bid item to a non-bid item
     In this situation, Medicare payment is only made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item.

   - Upgrades from a non-bid item to a bid item
     When upgrading from a non-bid to a bid item, Medicare payment is made to a contract supplier on either an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

   - Upgrades from a bid item in one product category (category "S") to a bid item in another product category (category "U")
     In this case, Medicare payment is only made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of lower of the actual charge or the fee schedule amount for the medically necessary bid item in product category "S".

Note: In the *Medicare Claims Processing Manual* chapter 36 section 40.11 attached to CR6119 at *http://www.cms.hhs.gov/Transmittals/downloads/R1532CP.pdf* on the CMS website, a detailed chart describe situations where a beneficiary, residing in a CBA, elects to upgrade to an item with features or upgrades that are not medically necessary.

Beneficiary Liability

Under the competitive bidding program, a beneficiary has no financial liability to a noncontract supplier that furnishes an item included in the competitive bidding program for a competitive bidding area, unless the beneficiary has signed an advance beneficiary notice (ABN). Similarly, beneficiaries who receive an upgraded item from a noncontract supplier in a competitive bidding area are not financially liable for the item unless the supplier has obtained a signed ABN from the beneficiary.

In the case of upgrades, for a beneficiary to be liable for the extra cost of an item that exceeds their medical needs, an appropriate ABN must be signed by the beneficiary. See chapter 20, section 120 of the *Medicare Claims Processing Manual* at *http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf* on the CMS website for additional information on ABN upgrades.

Billing Procedures Related to Downcoding under the Competitive Bidding Program

The following downcoding guidelines describe situations where Medicare reduces the level of payment for the prescribed item based on a medical necessity partial denial of coverage for the additional, not medically necessary, expenses associated with the prescribed item.

1. *For beneficiaries who reside in a CBA and for whom Medicare determines that the prescribed item should be downcoded to an item that is reasonable and necessary under Medicare's coverage requirements.*

    - Downcodes from a non-bid item to a bid item
      In this situation, Medicare payment will be made to any Medicare enrolled supplier on an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the single payment amount for the medically necessary bid item.

    - Downcodes from a bid item to a non-bid item
      Medicare payment in this downcoding scenario will be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

    - Downcodes from a bid item in one product category (category "U") to a bid item in another product category (category "S")
      In this case, Medicare payment will be made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of the single payment amount for the medically necessary bid item in product category "S".

2. *For a beneficiary who does not reside in a CBA, but travels to a CBA and for whom Medicare determines that the prescribed item is downcoded to an item that is reasonable and necessary under Medicare's coverage requirements.*

    - Downcodes from a non-bid item to a bid item
      In this situation, Medicare payment will be made to any Medicare enrolled supplier on an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item.

    - Downcodes from a bid item to a non-bid item
      Medicare payment in this downcoding scenario will only be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

- Downcodes from a bid item in one product category (category "U") to a bid item in another product category (category "S")
  In this case, Medicare payment will only be made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item in product category "S".

A detailed chart of downcoding scenarios is in the new Chapter 36, section 40.12 (attached to CR6119) for beneficiaries who reside in a CBA and for whom Medicare determines that the prescribed item should be downcoded to an item that is reasonable and necessary under Medicare's coverage requirements.

Additional Information

You can find more information about the payment changes for DMEPOS items as a result of the DMEPOS competitive bidding program and the Deficit Reduction Act of 2005 by going to CR6119, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1532CP.pdf* on the CMS website. You will find the updated *Medicare Claims Processing Manual* Chapter 36 *(*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program) as an attachment to that CR.

Additional information regarding this program, including tip sheets for specific Medicare provider audiences, can be found at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/* on the CMS dedicated website. Click on the "Provider Educational Products and Resources" tab and scroll down to the "Downloads" section.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.